General applications to medicine

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Doctor-patient communication

- A majority of doctors think they are good communicators, whereas a majority of patients are dissatisfied with the outcome of consultations.
- Communication skills can be improved by effective teaching, particularly with video-taped feedback. The most important component of such teaching is probably SENSITIZATION to one's own behaviour and its effects.
- Patient satisfaction can be broken down into a COGNITIVE COMPONENT dependent upon the doctor's verbal communication, and an AFFECTIVE COMPONENT dependent upon non-verbal communication.
- Interviews should be STRUCTURED, both so that the patient knows what to expect, and so the doctor can obtain the information they need from the consultation.
- Patients remember more information from interviews if the material is EXPLICITLY CATEGORIZED, is specific, uses short words and phrases, is repeated, uses POSITIVE ATTRIBUTION, and if the important items are presented first.

Learning communication from a book is as forlorn an enterprise as learning to ride a bicycle by reading about it; success requires practice rather than theory, and is best learnt from a skilled teacher who can see the problems, and help with difficulties. Bicycle books instead try to persuade that cycles are useful objects, that people differ in their skills on two wheels, that accidents can result from poor riding, that the machine is more enjoyable and effective when ridden with understanding, and that life is easier for all if a few social rules are observed; in other words, to help you realize it is more difficult and sophisticated than you first thought, but that the difficulties are surmountable.

Most doctors believe they communicate well (just as 80% of motorists think their driving is above average). Regrettably, surveys of patients suggest the opposite; a majority of patients are dissatisfied after consultations. Most doctors qualifying before 1970 had no training in communication, and those qualified since have received only a few hours. Surveys of interviewing suggest that students at the end of their clinical course are no more EMPATHIC (able to share

emotion) than those beginning their course, and are often worse at eliciting information.

Studies of communication skill courses show that they improve students' abilities to organize a consultation, to elicit important information, to establish rapport and form an empathic relationship, and to improve patient satisfaction. More importantly, those skills are still improved five years later when compared with controls. Probably the most effective teaching uses video-taping, followed by playback and discussion of problems, the feedback provided by the tape and the teacher being absent from conventional interviews. Nevertheless, all training seems to be helpful, suggesting that an important aspect of training is SENSITIZATION, becoming aware of one's own actions, of having control over the interview, of finding ways to change, and of assessing the impact of changes. To look at one's own behaviour as would an external observer, realizing where it succeeds and where it fails.

The Royal College of General Practitioners has defined good communication in general practice as follows:

> 'The doctor creates a receptive and calm atmosphere in the consulting room, and the patient is encouraged to communicate freely. He communicates his interest in the patient and his story. He actively explores the patient's view of the problem, and seeks to achieve a high degree of agreement between it and his own view of the problem. He gives evidence of his own commitment to the patient now and in the future. There is clear and adequate information on the services provided by the practice. The doctor's communication with the patient helps him to define the reasons for the patient's attendance at the surgery, to manage the patient's problems, to educate the patient on relevant health care problems, to offer support to the patient and to promote health in its broadest sense.'

For research purposes each part of such a definition can be assessed separately, trained observers rating interviewers for 'self-assurance', 'warmth', 'empathy', and 'competence'.

Patients can also be asked about how satisfactory was an interview. Broadly speaking, satisfaction has two components; *cognitive*, the doctor's verbal ability at conveying information and answering questions clearly; and *emotional* or *affective*, depending on non-verbal communication, to do with manner, attitude, warmth, friendliness and concern.

Success in communication can also be assessed in terms of effectiveness at achieving an outcome. Does the patient take the pills, lose weight, or stop smoking? If not, then there is a lack of COMPLIANCE, and at some level the consultation has failed. Poor compliance is common (Table 15.1), 44% of patients not adequately complying with a doctor's advice.

Table 15.1
Failure of compliance with medical advice in a range of studies. From Ley P (1977), in Rachman S, Ed, *Contributions to Medical Psychology, vol 1*, Oxford, Pergamon.

Type of advice		No of studies	Median percent of patients who did not follow advice
A.	Medicine taking		
i.	TB drugs	20	35
ii.	Antibiotics	8	50
iii.	Psychiatric drugs	9	44
iv.	Other medicines	12	58
B.	Diet	11	45
C.	Other advice e.g. child care, antenatal exercises	8	15
D.	All advice	68	44

A consultation is a complex social occasion. Lasting from five to fifteen minutes, each party brings their own expectations and hopes to achieve a specific result. The doctor hopes to understand the patient's problems, make a coherent diagnosis if possible, provide treatment as appropriate, and produce a satisfied patient. Medically, the most important component is the diagnosis, since from it all other decisions follow. Experimental studies suggest that a good history will provide 85% of the information for making a diagnosis, and examination and tests only about 10% and 5% of the information; the key to a good history is good communication. The patient has a different perspective. They have a problem, although it may not be the one they are telling the doctor (perhaps because they are too embarrassed or shy to mention their sexual or psychiatric problems). They want it diagnosed efficiently, thus inspiring confidence, to receive reassurance and honest, comprehensible information, and to obtain treatment as necessary.

Doctor and patient both make assumptions about the rules to be observed during a consultation. A recent study asked individuals what rules should be observed in particular social situations, including those for doctor and patient (Table 15.2). Although these are generally observed, it must be emphasized that if the patient's rules are broken, the doctor's social role is still to help the patient as far as possible; by contrast the doctor has a professional duty not to break the rules. If the doctor-patient relationship is compared statistically with other social interactions, then the doctor's role is seen as like both teacher and repairman, whereas the patient's role is similar to that of pupil and of householder (as it were, the owner of property needing repair).

Table 15.2

The social rules that a majority of the public feel should be observed by doctors when seeing a patient, and by patients when visiting a doctor. Reprinted with permission of the copyright holders from Argyle M and Henderson M (1985), *The anatomy of relationships*, Harmondsworth, Penguin.

By the doctor

1. Listen carefully to the patient.
2. Always explain very clearly.
3. Counsel on preventive medicine.
4. Be frank and honest.
5. Hold information obtained from the patient in strictest confidence.
6. Keep confidences.
7. Respect patient's wishes.
8. Don't criticize the patient publicly.
9. Look the patient in the eye during conversation.
10. Respect the patient's privacy.
11. Show emotional support.
12. Don't engage in sexual activity with the patient.
13. Come to a clear diagnosis.
14. Appear neatly or smartly dressed when with the patient.
16. Don't become personally involved with the patient.
18. Strive to present yourself to the patient in the best light possible.
19. Don't ask the patient for material help.

By the patient

1. Question doctor if unclear or uncertain.
2. Give doctor all relevant information.
3. Follow the doctor's instructions carefully.
4. Be completely honest.
5. Ensure cleanliness for the medical examination.
6. Don't waste the doctor's time.
7. Don't make unreasonable demands on the doctor's time.
8. Have confidence in the doctor.
9. Respect the doctor's privacy.
10. Present problems at one time.
11. Look the doctor in the eye during conversations.

Verbal behaviour. Systematic studies of students communicating with patients find several common problems. INSUFFICIENT INFORMATION is elicited, important symptoms are missed, or whole areas are simply omitted, particularly about social background, psychological response to illness, or occupation. Sexual or marital problems are mentioned by patients but then not followed up by an embarrassed doctor, despite being the patient's main concern. Many problems of elicitation arise because the doctor FAILS TO CONTROL THE INTERVIEW, letting the patient ramble on about irrelevancies, or because of LACK OF CLARIFICATION, hints not being followed up when they are made. Alternatively, the interview may be UNSYSTEMATIC, with no set topics to be covered in any interview. Information may also not be elicited because the wrong questions are asked: they may be LEADING QUESTIONS ('And I suppose there is nothing wrong with the bowels?') in which a particular answer is anticipated; they can be too complex because of TECHNICAL LANGUAGE or JARGON ('Any recurrence of the melaena?'); they may use EUPHEMISMS which are not understood ('How are the waterworks?', 'Oh, you mean my urinary tract!'); or they may use verbal constructions, involving passives, double negatives, or unusual words which are beyond the patient's intellect. Finally, many questions in natural speech are unintentionally several questions, without a simple, obvious answer: 'Any problems with the chest... or heart... or the circulation?'

Problems also arise when patients do not know what to expect. Particularly in hospital, patients do not know *who* is talking to them, *why* they are talking, *how long* they will be talking, and *what* the interview is for. Patients may have something they wish to say, or questions they want answered, but find the opportunity never arises, as the interview suddenly finishes without warning.

Non-verbal behaviour. Non-verbal behaviour (see Chapter 6) reveals many subtle nuances of meaning, as in the tone of voice, a look in the eyes, head position, the holding of arms, etc. Freud suggested, 'he that has eyes to see and ears to hear may convince himself that no mortal may keep a secret. If the lips are silent, he chatters with his finger tips...'. Such non-verbal communication occurs in both directions, with the patient also receiving messages about the doctor's attitudes: warmth is perceived from leaning forward toward the patient rather than sitting back in the chair; firmly folded arms indicate coldness, rejection and inaccessibility; gazing around the room, or writing while the patient talks, indicate indifference and lack of concern; and an occasional sympathetic smile or nod of the head, along with a muttered 'Hmmm...' are FACILITATIVE and indicate willingness to listen further. The most difficult non-verbal signal is silence. After asking a difficult direct question, particularly about emotionally disturbing problems, then CONFRONTATION, a sustained silence, accompanied by direct, prolonged eye-contact, will help a

patient to talk, but only if the doctor resists the overwhelming desire to break the almost unbearable silence, which can almost be cut with a knife. Psychiatrists and psychotherapists are masters of the art of the FACILITATIVE SILENCE, and an expert should be carefully observed at work.

The placing of doctor and patient also sends non-verbal messages; the patient in a hospital bed or on a trolley, especially lying flat, feels inferior, subservient and unimportant, making communication difficult, and the patient likely to use the ego-defence of REGRESSION. Sit the patient up in bed, support them with pillows, and sit yourself on the edge of the bed, or in a chair, so your heads are at the same level; literal talking down easily becomes metaphorical talking down. Some medical students spend time as surrogate patients, experiencing the disorienting effects of confinement to bed, of being wheeled on trolleys, of being talked over and about by professionals apparently unaware of the patient's existence. Such experiences are recommended to all students. Alternatively, talk to colleagues or relatives who have been in-patients.

Much that is important, both verbal and non-verbally, concerns what is *not* said. Parents of newborn children with Down's syndrome describe how they first knew the problem, long before formal communication:

> 'I knew something was wrong as soon as he was... born. They all looked at each other and then went very quiet. Some other people then came in... but when I asked was he all right, they said he was fine and not to worry... but I knew they knew all the time, so why didn't they say something instead of keeping me wondering and worrying all that time?'

> 'I guessed she wasn't all right. She was always the last baby brought up from the nursery for feeding and people, doctors, students and nurses and all that, kept popping in to see us but never seemed to want anything...'

The medical consultation is unique in allowing close physical proximity between strangers, the examination involving intimate looking and touching. Physical intimacy without psychological intimacy is legitimized by the formality of the relationship, and the professional demeanour of the doctor. Needless to say it should be respectful, unhurried and careful. A patient will be more relaxed if the doctor starts by examining the least sensitive parts, such as eyes, face, and hands and gradually moving to chest, abdomen, groins and perineum. Patients should not be naked, for thus lies humiliation and severing of confidence, and should be covered with a sheet as far as possible. Many patients are fearful and nervous because they do not know why certain things are being done; a few words will calm.

Patients also know that some things *should* be done; the application of stethoscope and sphygmomanometer inspires confidence even when the complaint is of an ingrowing toe-nail, and avoids the accusation of 'Well, I wasn't examined properly!', and a thorough examination occasionally reveals the real concern to be for a lump in breast or scrotum.

Patients have their own ideas about how doctors should act, how bodies work, about what is important for health and about treatments. Such HEALTH BELIEFS may be wrong, or even absurd, but must not be ignored or laughed at; instead they should be exploited to help the patient. As an example of erroneous beliefs, Figure 15.1 shows the ideas of four patients about the location of organs within their bodies. Needless to say, ideas about physiology and pathology can be far more confused.

The therapeutic benefit of a consultation often derives from the implicit psychotherapy carried out by the doctor, and its power should not be neglected. In recent decades such skills have been neglected at the expense of increasing prescriptions for psychoactive drugs. It is now accepted that a doctor's sympathy and concern, coupled with genuine, understanding reassurance are often sufficent to treat minor psychosomatic and neurotic complaints without drugs; as Michael Balint put it, the doctor is a powerful active drug whose specific effects should be used whenever possible.

Successful doctor-patient communications have STRUCTURE and are not just a rambling chat. The structure helps the *patient* orient themselves, know why the interview is taking place, and helps them remember the important parts. The structure helps the *doctor* obtain necessary information systematically, and emphasizes the doctor's professional competence. Maguire's model of a clinical interview distinguishes CONTENT (the information obtained) and TECHNIQUE (the means of getting the information). The doctor should obtain *information* about:

i. *The main problem*: there may be several and the first mentioned may not be the real one.
ii. *The impact of the condition on patient and family*: social and psychological consequences, which may be of more *practical* consequence than the physical problems.
iii. *The patient's ideas about the problems*: serious or trivial? Why do *they* think they have it? What might make it better or worse? What treatments should be used?
iv. *Predisposition to developing similar problems*: is there anything in the patient's background that the *patient* thinks is relevant, either physically (family history, occupation) or psychologically (early experience, etc.)?
v. *Screening questions*: a systematic (but perhaps brief) history

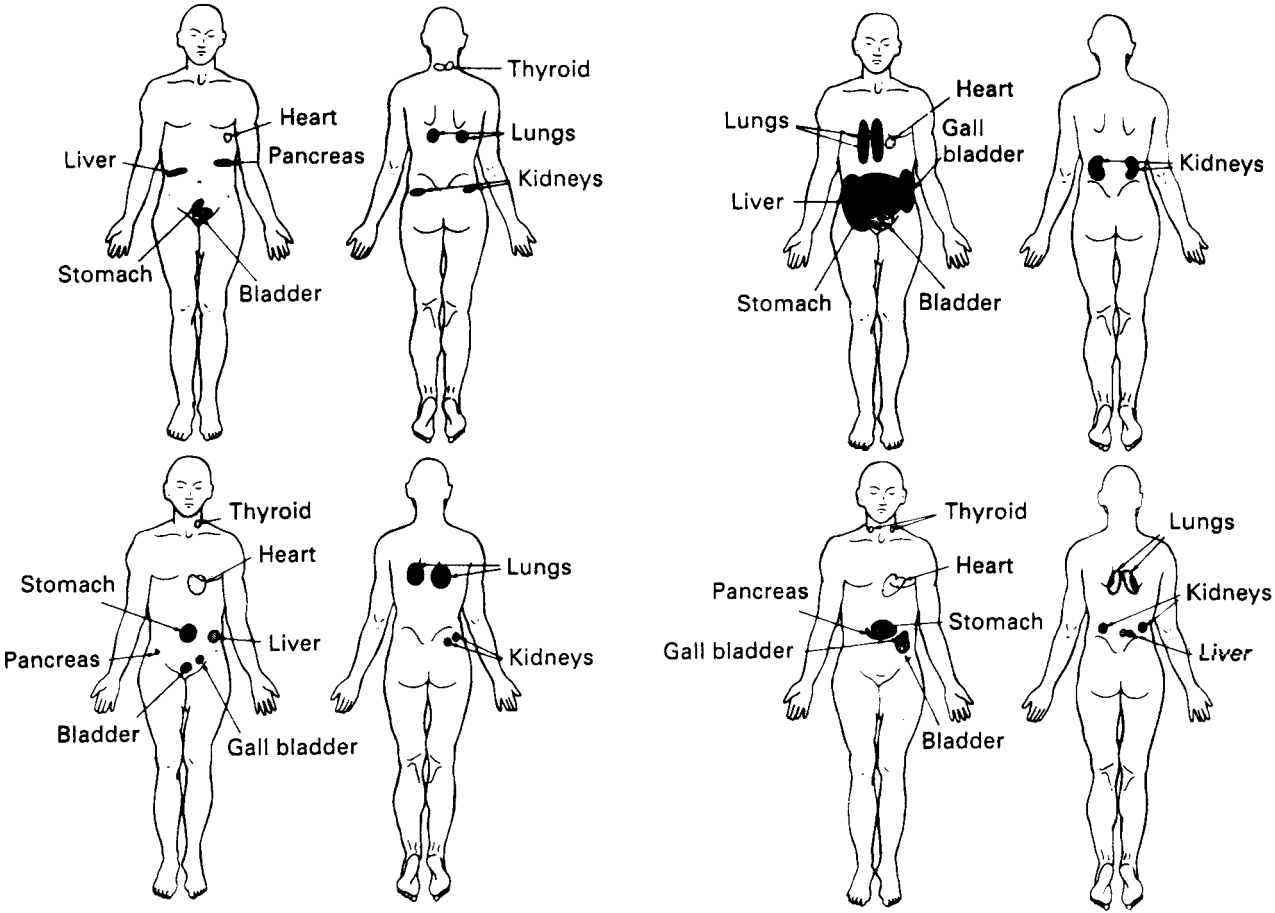

Fig. 15.1 Patients' diagrammatic descriptions of their ideas on the location of various organs of the body. Reproduced with permission from Burnett A C and Thompson D G (1986), Aiding the development of communication skills in medical students,

covering the bodily systems, and social and psychological factors, to avoid omission or suppression of relevant information.

The technique for obtaining the information is:

i. *The beginning.* The interviewer greets the patient, shaking hands if appropriate, and introduces themselves both by name and status (but do not expect them to understand the convoluted medical hierarchy of consultants, registrars, SHOs, etc.). Particularly in hospitals, doctors often appear in scrub gear, or plastering apron, and the patient will not know that they are a doctor, as so many persons in a modern hospital wear a white coat. Patients should be greeted by name, both as a common courtesy, and to avoid confusion between patients. The first name should not be used, unless the patient is genuinely well-known to the doctor, and the patient would also call the doctor by the first name; false, 'chummy' use of the first name is off-putting, and is offensive to older patients, for whom the spouse may be the only person who calls them by their first name, and to any one who ordinarily uses their second name.

ii. *Explanation of the structure of the interview.* The doctor should indicate why they are there (the patient may have seen several other doctors or students), what sort of information will be elicited, and the reasons for it. This stage not only puts the patient at ease, but allows them to compose their thoughts, and organize themself for the interview.

iii. *The interview proper.* Although primarily designed to elicit information (at least from the doctor's point of view), also listen carefully for hints of hidden or unacknowledged problems. Many doctors are too ACTIVE or DOMINANT, asking questions when they would better be listening. Much psychotherapy and NON-DIRECTIVE COUNSELLING requires almost *only* that the doctor be a good listener, the patient resolving their own problems, by bouncing them off the doctor.

iv. *Ending the interview.* This can be surprisingly difficult. Make the patient aware that the interview is finishing, summarize what the patient has said, check salient facts for accuracy, and give the patient a clear opportunity to ask further questions, or volunteer further information. Finally, thank the patient for their time, and indicate when doctor and patient are likely to meet again.

Consultations frequently end with a diagnosis, advice and, perhaps, a prescription. Such information is designed to be remembered (if not remembered, it is pointless). Much is actually forgotten, and Ley's recommendations, based on experimental studies in general practice, increase recall.

i. *Explicit categorization.* Put material into clear categories, a proven

method for helping memory in many situations (including exam preparation).

'I am going to tell you:
— What is wrong with you;
— What tests will be needed;
— What will happen to you;
— What treatment will be needed;
— What you must do to help yourself.
Firstly, what is wrong with you...
Secondly, what tests we are going to carry out...
Finally, what you must do to help yourself...'

This simple technique increased patient's recall of advice from 28% to 65%, of miscellaneous information from 46% to 70%, and of the diagnosis from 60% to 66%.

ii. *Specific rather than general statements.* 'You must lose two stone in weight', or 'You must take two weeks' holiday', rather than 'You must lose some weight' or 'You must relax more'. Recall increased from 20% to 50%.

iii. *State important pieces of advice first.* The primacy effect (see Chapter 4) means that early items are remembered better than later items. Most consultation summaries start with the diagnosis, which is very salient and remembered well anyway, and advice on life-style comes later. If life-style advice is important then placing it first aids recall. 'You must lose more weight... because the arteries to the heart are being affected' rather than 'The arteries to the heart are being affected... and so you must lose more weight'.

iv. *Use short words and short sentences.* Studies of patient information leaflets, included with drugs, or given before X-ray examinations, show that those containing easier reading material, and hence readable by more of the population, are understood and remembered better. The same applies to verbal material: keep sentences short and use common words. Such advice seems so self-evident as to be unnecessary, except that much literature for patients actually requires a reading ability possessed by only 5% of the population (Fig. 15.2).

v. *Repetition.* Repeated items are remembered better. If an item is important, repeat it. Important items should be repeated. Repetition emphasizes the point.

vi. *Positive attribution.* Persuasion or advice often contains implicit criticism, which is threatening ('You must lose weight [and I have to keep telling you because of your lack of self-perception, will-power, and intelligence]'). Positive attributions convert advice into a compliment, which is more likely to be remembered and to be acted upon: 'I'm sure that a sensible person like you realizes the health hazards of overweight, and will be keen to lose some weight'.

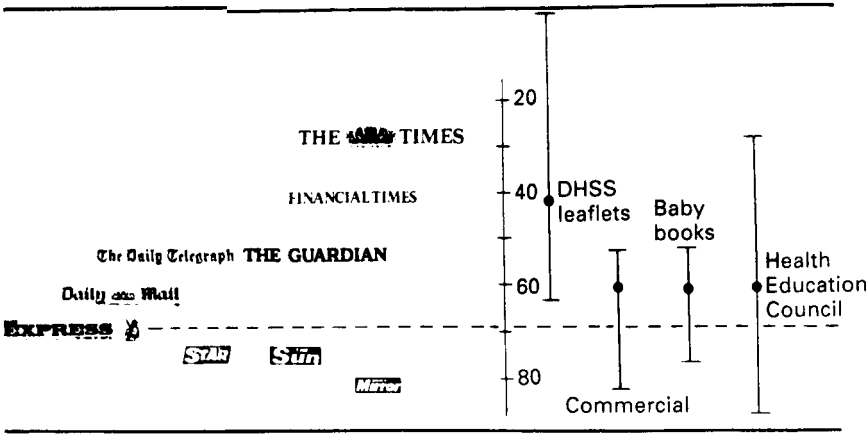

Fig. 15.2 The 'readability' as indicated by the Flesch score of a range of daily newspapers, as compared with patient information leaflets issued by various bodies. The dashed line is the average reading ability for the population. Reproduced with permission from Polnay L and Hull D (1985) *Community Paediatrics*, Edinburgh, Churchill Livingstone, 48.

There are no simple formulae: the attribution must be made to measure.

This chapter has introduced the problems of communication, particularly of oral doctor-patient communication. It has not talked much about written communications, and has not considered communication with other health personnel, such as other doctors, nurses, paramedical staff, etc. Nevertheless, I hope it has convinced you that communication matters, that it can be improved, particularly with skilled help, and that the most important step towards improvement is *realizing* that it matters; doctors who are bad communicators on leaving medical school probably remain bad communicators throughout their careers.